Semon and Horsley's experiments, as interpreted by McBride, and rather supports the older etiology.

A singular and interesting fact in connection with the recovery of the voice in this case, I learned recently, and I mention it because I have never seen any reference to the like in literature.

When she regained her voice it surprised her as much as it did her auditors. As she expected to speak in a whisper as had been her wont for eight months, she was greatly frightened at the sound of her own voice, sent for her husband and in the midst of tears told him that she knew she was going to die—that this was a token. Her husband laughed her fears away, telling her the doctor had told her she would again be able to talk. Now comes the interesting phenomenon: after having conversed in a whisper for eight months, on recovery of her voice, it was *impossible* for her to whisper. She tried repeatedly, but each effort to whisper resulted in distinct phonation and clearly articulate speech.

The conclusions which, I think, clearly follow from the notes on the above cases are:

1. That we may have a paralysis of the arytenoideus muscle, due to the most usual cause, viz., acute cold, recover suddenly—just as hysterical cases recover—hysteria being a probable factor delaying recovery.

2. That we may have hysterical aphonia supervene upon an old case of unilateral adductor paralysis, where only weakness of the voice was present, leaving the voice only slightly impaired from the old lesion, the latter being still in force and unaltered as shown by the laryngeal image.

3. That authors differ widely as to the etiology and even existence of unilateral adductor paralysis, and that this field is a legitimate one for investigation, if for no other reason for the sake of rational and in consequence more successful therapeusis.

4. That as long as diametrically opposite views are held by such authors as I have quoted, concerning its etiology, students will be confused rather than taught by the multitude of contradictory statements.

5. That the greatest care should be taken before making a positive diagnosis in all cases of neuroses of the larynx, as the chances of error are numerous, and downright mistakes harmful in many ways.

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HISTORY OF A CASE OF RECURRENT NASAL FIBROMA.

Read in the Section on Laryngology and Otology, at the Forty-sixth Annual Meeting of the American Medical Association at Baltimore, Md., May 7–10, 1895.

BY PRICE BROWN, M.D.
TORONTO.

I must request your forbearance with me, for taking up your valuable time with the report of a single case. We all know how little weight can be attached to individual histories, and that it is only by accumulated evidence that we can be guided to a proper estimate of the value of clinical research. If this is true in reference to surgical practice, it is equally true of a wide range of subjects pertaining to our own special field. Still, there are lesions in which the individual histories are so few and the few so widely spread over time as well as territory that it would seem to behoove every observer to chronicle each instance as it occurs with the hope of adding a fraction, however minute, to the information already possessed. This I am inclined to think is true of nasal fibroma, and as the case I have to report presents several interesting features I trust you will bear with me while I briefly detail its history:

On Nov. 30, 1894, Mr. A. V. P., aged 22 years, stenographer, consulted me about a growth located in the posterior half of the right nasal passage. He was a hemophilia; had had no specific disease. Family history good. Parents both living and healthy. No relatives, so far as he could remember, had been afflicted with malignancy or tuberculosis. Five years ago he discovered a somewhat hard dark-colored growth in the right nasal passage just within the choana. His voice at the time was nasal and it was almost impossible to breathe through the right naris. He consulted a specialist, who snared off a piece. This produced profuse hemorrhage, which, however, soon ceased. At different sittings during the next few weeks the snaring operation was repeated six or seven times; each time the bleeding was severe.

As the tumor seemed to grow almost as rapidly as it was snared away, a microscopic examination was made and the disease was pronounced to be sarcoma. On further consultation with general surgeons, it was advised that a portion of the right maxilla be removed and a silver plate inserted, the case being considered one of malignant disease. This, however, his people declined to consent to, and he was sent to Boston and placed under the care of Drs. Packard and McDonald, of the Homeopathic Hospital. He remained there two months and during that time had several operations performed under ether. The nature of these he could not tell, except that they were intra-nasal, attended by exhausting hemorrhages, and that the nostril after each operation was tightly plugged. At the expiration of the period mentioned he was well enough to return home. The doctors told him that they had removed the whole of the tumor, with the exception of a little piece at the back end of the passage, upon which they did not think it advisable to operate at the time. During the following summer he had for months slight daily hemorrhages, but he spent the season in the country and they eventually ceased. For the next three years he had so little nasal trouble that he did not think professional advice necessary. About a year ago, however, occlusion of the posterior end of the right nasal passage began to return; crusts would form which he found it difficult to void, and slight hemorrhages would also sometimes occur. In November the physician he consulted referred him to me.

The entrance to the right nasal passage was somewhat narrow, but immediately behind it was a wide, open cavity for about one-half the normal depth of the passage. There seemed to be complete absence of the inferior turbinated bone; probably removed by surgical operation in Boston, as already related. About an inch and a quarter from the anterior naris the passage was completely filled by a bright reddish growth springing from the septum, the vault above and the middle turbinated. The attachment on the septal side extended down to the bottom of the inferior meatus. The uvula was very long. Posteriorly, the tumor filled the whole of the nasal cavity. It extended behind the septum, which it seemed to have pressed to the left. On the right it was attached all the way down to the floor of the naris and lay immediately anterior to and continuous with the Eustachian tube. This tube occupied a plane considerably posterior to the left Eustachian, no doubt owing to the pressure of the tumor.

In other respects the health of the patient was of an ordinary character with the exception already mentioned, that he was a hemophilia. He told me that the extraction of a tooth would be followed by bleeding for hours, as also would the slightest cut or scratch.

The question of the best method of operating in this case was difficult to decide. With so extensively sessile a growth, with base concave from side to side, snaring would be impossible, except in small fragments and by following out Ingals' method of galvano-cautery notches, prior to adjusting the snare. His hemorrhagic tendency also seemed to contraindicate treatment by this plan. Curetting, cutting away by knife or scissors also seemed out of the question on the same ground, as well as owing to the

obscurity of the situation. Post-nasally, but a small portion of the growth could have been reached.

Direct surgical operation by excision of the superior maxillary and palatal bones did not seem to be required, as I did not believe these bones of themselves to be seriously involved. There was no external deformity and the only displacement in the pharynx was a pressure downward of the right side of the soft palate. Electrolysis I thought of, but having had no personal experience of its effects in deep nasal work, I finally decided to endeavor to dissect it out, little by little, with the galvano-cautery knife.

On December 1, I did uvulotomy to facilitate post-nasal observation. Two days later, after applying 20 per cent. solution of cocain, I made the first galvano-cautery incision through the anterior naris into the lower part of the tumor at its union with the septum, continuing the burning until the hemorrhage became quite severe. An astringent spray soon controlled the bleeding. Several days later I repeated the operation in the same way, but at the outer margin of the growth at the site of the junction of the former inferior turbinated with the maxillary bone. The hemorrhage this time was very severe and I found it necessary to plug with kite-tailed tampons of absorbent cotton packed solidly within the nasal cavity. This stopped the flow and twenty-four hours later upon removing them, there was no recurrence. After an interval of a week I made the third attempt at galvano-cautery work, incising the central portion between the other two cuts. The electrode was of a bright red heat, and it had only been applied a few seconds when arterial blood began to jet out forcibly. The flow was so rapid that with difficulty I caught a glimpse of a large pulsating artery laid bare and opened by the cautery. It seemed to run across from the septum to the external wall. Having had such a satisfactory result from the previous packing, I again resorted to it. The patient lay down in my office and for a few moments the bleeding was checked. Then it began again, escaping by the posterior naris and soon became alarming. Dr. Reeve kindly came to my assistance and after removing the plug, I packed the cavity from behind by the use of Belocq's canula, having first soaked the sponges with a combination of tannic and sulphuric acids. This effectually stopped the bleeding, but the patient was almost pulseless by the time it was accomplished, and two hours later, when being assisted to the carriage, he fainted away. This loss of blood confined him to bed for a week, and two more elapsed before he was well enough to proceed with operations again.

On looking up the literature of fibrous tumors of the air passages, I found that Kaarsberg of Copenhagen, in 1894 recommended electrolytic treatment of fibrous tumors of the naso-pharynx, giving the history of four cases, the treatment being supplemented by the use of the galvano-cautery and scissors, and I decided to try it in this case of fibroma of the nose.

After applying a 20 per cent. solution of cocain, as in the cautery work, I used long needles, isolated by rubber tubing, and inserted through the anterior naris into the growth at a distance of about half an inch from each other. These were attached to a 12 cell Le Clanché battery. The séances were about five minutes each, and given upon alternate days.

Notwithstanding the anesthetic effect of the cocain, the shock was very painful, even more so than that of the galvano-cautery. The effect upon the tumor was of a deadening nature, making the surface paler and producing exudation. The shrinkage, however, was scarcely perceptible. After using it through the anterior naris three times, I changed the direction of the electric current, by passing a single straight needle into the tumor from the front, and a long curved needle through the mouth and naso-pharynx and into the growth from behind. This seemed to produce a more satisfactory effect. The central portion, both anteriorly and posteriorly lost much of its vivid hue, though the shrinkage produced by four séances was almost *nil*.

Hoping by this time that the electrolysis would have the effect of limiting the severity of future hemorrhages, I again returned to the use of the galvano-cautery.

From January 18 to March 15 I operated with it at sixteen different sittings, each time applying the cautery as extensively as I thought I could do with safety. Sometimes there was no hemorrhage; at others it was only slight, never severe enough to require plugging. Little by little I got the growth away. The first half of the operations were performed entirely through the anterior naris, the vision of the parts being obtained through the anterior rhinal speculum. The latter half, also, were done through the anterior naris, while the operations were guided by the posterior rhinal mirror.

To complete the work, as the pharyngeal tonsil was somewhat protuberant, I removed it with Gottstein's curettes as a precautionary measure. The bleeding from the cuts was severe, but was checked without plugging.

In the cautery work, the part I found most difficult to accomplish, and requiring the greatest care in manipulation was the destruction of the part of the fibroid attached to the anterior margin of the Eustachian tube.

The supplementary treatment consisted of daily cleansing with alkalin spray, followed immediately by removal of crusts, sloughs, etc., with the aid of cotton holders and finishing with spray of albolene.

I had sections of the tumor examined by a competent microscopist; he pronounced it a dense close grained fibroma.

With regard to the physical condition of the patient, the course of treatment was very satisfactory. With the exception of the time lost as the result of the excessive hemorrhage, he never lost a day from his professional duties. The operations were always done in the evening. Sometimes he would be restless and suffer pain during the following night, but he could always take a light breakfast and go down to his office the morning afterward. During the latter half of the treatment, notwithstanding the amount of cocain used he improved in weight, as well as in color and spirits, and I am glad to say without acquiring the slightest craving for the drug so frequently used.

One notable feature in the history of the treatment was the extent to which the palate resumed its natural functions. At first being pressed out of position it had no control over sprays thrown into the nose, and would allow them to trickle over and to drop into the larynx with paroxysmal coughing as a result. Latterly this accident would never occur, and the nose might be filled with fluid without any escaping into the lower pharynx. In fact, the control over the velum acquired by the patient aided very materially in the treatment of the case, and during this period I exhibited him to the Toronto Medical Society, so that the members could examine the tumor while still in the process of removal.

I have called this a case of recurrent nasal fibroma, believing that the original attack from which the present one must have developed was really fibroma instead of sarcoma. That the former may degenerate into the latter is, I believe, a recognized pathologic fact, but that a malignant growth could be the parent of a benign one, is certainly open to question.

What the future of the case may be it is impossible to say. At present there is no indication of any tendency to return. A new mucous membrane has re-formed. The throat is moist and the voice normally resonant. Still, that it has been completely and finally eradicated seems almost beyond hope. The case, though interesting, is too recent to base a correct conclusion upon, and I shall watch the future history with more than ordinary solicitude.

DISCUSSION.

DR. WARD, of Pittsburg, mentioned a case he had under treatment of a young man about 16 or 17 years of age. About seventeen months ago he suffered from the effect of a large growth in the naris and the incidental symptoms,

obstruction, retained secretions, etc., were quite marked. The growth protruded from the naris and extended backward into the pharynx. He was in a pitiable condition when he entered the hospital. Dr. Ward attacked the growth with the snare and removed it *in toto*. The size of the tumor was fully as great as a hen's egg. Microscopic examination proved it to be a fibro-sarcoma. The hemorrhage during the operation was very profuse, but as soon as the growth was removed it ceased of itself. A few months ago the growth began to develop again and he was sent back to the hospital. What the result will be, it is impossible to say.

DR. E. FLETCHER INGALS, of Chicago, said that he had never had any experience with fibrous tumors in the nasal cavities, but recalled a number of such growths in the naso-pharynx which extended slightly forward into the nasal chambers. He had removed some with the galvano-cautery ecraseur. On others, he had used electrolysis with good results, especially in sessile growths where there was difficulty in getting the loop of wire around their base, and he found that they disappeared under electrolysis. At present he has a little fellow under observation in whom a fibroid tumor began to grow in the naso-pharynx and he had removed it with the galvano-cautery. It subsequently returned, and in six sittings he was able to destroy almost the whole of that which appeared in the naso-pharynx, but it had since extended downward to the malar bone and the nasal chambers. This, he supposed, might be called a recurring fibroid of the nose. It is difficult to decide how to treat these cases, but as he had obtained good results already from electrolysis, he purposed continuing it after returning home.

DR. LOGAN, of St. Louis, said that his experience had been in accord with the previous speaker with regard to the prevention of hemorrhage by the use of electricity in removal of naso-fibroma. He employs both the electro-cautery snare and the electro-cautery knife and found them useful both in removing the growth and in checking hemorrhage.

DR. CLINE, of Indianapolis, referred to the case of a boy 16 years of age who had been under his observation during the past year. He had a pretty large growth occluding the nose and extending into the pharynx, perhaps the size of a small orange. The side of the nose was pushed out and the eye was dislocated to some extent. With the galvano-cautery snare he had cut off about one-third of the tumor, which on examination was pronounced a fibro-sarcoma.

DR. E. L. VANSANT, of Philadelphia, said that in regard to the diagnosis of these cases of tumors occurring in the naso-pharynx, as Dr. Brown had raised the point in the discussion, he would make the following observation. He had made a number of histologic examinations in these cases and had come to the conclusion that the diagnosis depends very much on what part of the tumor the section comes from. If it is taken from the outer layer of the growth, you will probably get a very fair specimen of sarcoma, because of the proximity of the mucous membrane and the proliferation of cells near the surface. From a deeper layer you will probably get a very fair specimen of fibro-sarcoma or fibroma. In these cases there are large venous channels which are likely to cause troublesome hemorrhage. In some parts of the growth there may be spots of softening, and sections through them may give the appearance of myxema, myxofibroma. These are due to a process of degeneration, the tumor being at first a fibroma, which undergoes sarcomatous change, subsequently myxomatous degeneration takes place, forming cysts in the growth. The fact that these large vessels are formed, explains the hemorrhage, unless the galvano-cautery is used. He declined to say whether the paper had the proper title or not.

DR. PRICE BROWN in closing, said he was glad that his paper had brought out the history of so many cases. In one respect his case differs from other cases reported; it was a sessile growth over the whole cavity of the nose, springing from the upper part of the septum, the vault above and the middle turbinated body on the other side. He was glad to have his experience with electrolysis confirmed both by Dr. Ingals and Dr. Logan, and especially in regard to its value in reducing hemorrhage. He had some doubts about the correctness of the title of his paper. The growth had been at first pronounced a fibroma by doctors who had seen the patient, and it was regarded as sarcoma when it was removed in Boston. Three years later it came to me and I considered it fibroma. It would be of interest to know if it can be properly called a fibroma if the preceding growth was a sarcoma.

THE CHAIRMAN—Was the growth after both operations examined by the same men?

DR. BROWN—No, it was not.

STATE MEDICINE vs. FADS.

BY GRANVILLE P. CONN, A.M., M.D.
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It is often interesting, as well as instructive, to take a retrospective glance over conditions that apparently have taken the lead in shaping popular opinion. In professional work this is quite as fascinating as it is to follow the ordinary topics of the day. In the present, matters that are non-sensational are relegated to the background, giving place to topics that can be made to excite the imagination, and help to create a sensation. Out of this has been developed the fad of being interviewed by a representative of the public press; in which, many times, the person being interviewed is shrewdly made to say what the publishers of the paper or journal believe will be graciously received by its patrons. This seems to have extended to all classes of society until it has become a profession. The ward politician discourses eloquently on the financial problems of the day; the would-be statesman is represented to have decided views upon questions involving international law; ministers and lawyers do not hesitate to boldly proclaim to the world the necessary reforms to save the country, (yet it is rare that any two agree upon the plan of its salvation); the physician and surgeon allow professional work of the most sacred character to be heralded through the columns of the daily press as a consequence of reporters being present at operations, or of bulletins being issued daily, describing the physical symptoms of some prominent patient. In either case, by using the clinical phraseology of the surgeon or physician in charge, the language may be made so effusive as to leave the reader in doubt whether it is intended for the purposes of stock exchange, or for complimentary allusions of a mutual admiration society.

These professional fads have been developed from time to time, and it has always been the province of rational medicine (which is only another name for State Medicine), to assist in showing up what is fallacious and promoting the growth of what is good. State or preventive medicine is doing the same to-day, and to meet these questions successfully must adhere strictly to the truth, or to what can be satisfactorily demonstrated, without recourse to what may be justly denominated imagination and theory.

These conditions have been developing rapidly during the past decade. Conservatism seems to have been lost in the desire to bring before the public matters that would allow a greater range of the sensational, and solid facts have been made to give place to results that have been illusionary in their character.

In our professional work, preventive medicine may not seem so brilliant as surgery, nor so seductive to the general practitioner as the administration of drugs, yet the fact that a life may be saved without the intervention of either the knife or a drug, is a most gratifying result to the average human being. The advanced position that surgery has taken since the close of the late war, has been almost entirely along the lines of hygiene. The Army surgeon was oftentimes brought in contact with much that was suggestive, and with the broad and brilliant mental capacity which he must necessarily have in order to succeed, saw much appear that he would wish to improve. The unfortunate surroundings, the